

## Chapter 2

### **South African young people's sexual dynamics: implications for behavioural responses to HIV/AIDS\***

Christine A. Varga

*Health Transition Centre, Australian National University, Canberra*

#### **Abstract**

**HIV infection among South African youth is escalating rapidly. Recent (1998) estimates suggest that 21 per cent of women between the ages of 15 and 19 years are infected, nearly double the previously recorded (1997) rate of 12.7 per cent in this age group. This chapter explores the potential contribution of sexual dynamics to the spread of HIV among youth. Data were collected through focus-group discussions, narrative research method, and in-depth interviews. Study participants were Zulu-speakers aged between 11 and 24 years. Results suggest that safer sexual practices and partner agreement on means to prevent HIV infection are hindered by several factors, including sexual violence and coercion, condoms' negative symbolism, gender imbalance in sexual decision-making, and peer pressure concerning sexual performance. Nonetheless, there are signs of potential for behavioural change. Awareness of HIV's life impact and self-perceived risk of infection is growing. Young people are questioning gender stereotypes leading to unsafe sexual behaviour.**

A girl ... hesitates to use a condom if she knows she has a disease and she wants to infect others so they will die... (rural man, 21 years old)

I think men are more hesitant [than women] to use condoms because they want to spread AIDS... condoms would stop them from infecting other people (urban girl, 12 years old).

I think it is a fine thing to use condoms, because people are dying of AIDS here (urban boy, 12 years old)

This chapter focuses on the potential effect of sexual dynamics on young people's behavioural responses to HIV/AIDS. The data presented here are drawn from the preliminary results of a 12-month study currently in progress. The work investigates relationships between sexual decision-making and negotiation and reproductive choice among rural and urban youth in KwaZulu/Natal Province, South Africa. Several factors with potential influence over HIV-related behaviour are examined. Matters directly affecting HIV-related practices, such as attitudes toward condom use and self-perceived risk for infection, are described. Also explored are issues more deeply embedded in young people's socio-sexual environment: factors such as partner and peer pressure, and the role of sexual violence and coercion in shaping individuals' sexual choices. Ultimately, these data provide reasons for both despair

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and optimism concerning the potential for South African youth's behavioural change in response to HIV/AIDS.

The quotations above provide examples of the diversity of opinion among young people participating in the study. The first two comments speak volumes about the views of youth on HIV/AIDS, condom use and members of the opposite sex. Clearly, both speakers are fully aware not only of the implications of HIV infection, but also of the means to avoid it. Quite chilling is the suggestion in both speakers' statements that an apparent barrier to condom use is the fact that those infected with HIV want to spread it deliberately (see also LeClerc-Madlala 1997). These statements also illustrate the misconceptions which young people hold about members of the opposite sex with regard to sexual motivation and practice. In this respect, among the most significant findings in the study thus far is the fact that young men and women face similar constraints when attempting to negotiate the terms and conditions of sexual relations. While the last speaker by no means represents the majority of study participants, he is a member of what appears to be a growing minority of young people in both rural and urban areas who do recognize the need for safe sex practices in order to prevent HIV spread.

Although the study which forms the basis of this chapter is not concerned specifically with HIV-related issues, youth have continually raised AIDS as a matter affecting their sexual and reproductive experiences: testament to the dominant role this disease plays in their lives. Participants' reactions to HIV/AIDS have been very mixed. Some, like the 12 year-old boy quoted above, appear to have internalized the severity of the epidemic, and seem willing to personalize safer sex choices despite continuing social stigma regarding practices such as condom use or abstinence. Other young people are caught in an environment of conflicting pressures which (often against their will) necessitate their engagement in risky sexual practices. Still others do not appear to feel personally at risk of infection, despite acknowledgement that HIV/AIDS is a significant social health problem. In the midst of these differing opinions, at least two things are certain concerning youth and HIV in this study. First, they are acutely aware of HIV's presence in their communities. Second, HIV is a frequent topic of discussion among South African young people and a matter which figures prominently in their sexual life histories.

### **HIV/AIDS in South Africa: the numbers**

In recent years, the HIV epidemic in South Africa has escalated with a swiftness that is difficult to comprehend. Though the first few cases were identified in 1982, as late as the early 1990s infection rates remained low in the general populace. The first (1990) national sentinel survey among public antenatal clinic attenders revealed a seroprevalence of 1.2 per cent. Thereafter, however, it increased rapidly; within two years it had doubled to 2.5 per cent (Preston-Whyte 1994). In the next four years HIV infection rates increased even faster, so that by 1996 the national seroprevalence was 14.2 per cent. The latest (1998) national survey revealed 22.8 per cent seroprevalence; a 42 per cent increase over the previous (1997) figure (National HIV Survey 1998).

Such HIV rates make South Africa among the hardest-hit countries in the world (UNAIDS 1998a); it is one of the few countries with HIV seroprevalence over 20 per cent in the general population. Moreover, some sites in rural KwaZulu/Natal Province have recorded up to 40 per cent seroprevalence (National HIV Survey 1998; Smith 1999). It is estimated that 1500 new infections occur daily in South Africa; this translates to over 4 million South Africans infected with HIV, the vast majority of whom are probably unaware of their status (Sidley 1998; UNAIDS 1998b). According to some estimates, in 1998 approximately half of all new infections in the southern African region occurred in South Africa (UNAIDS 1998c).

Further, South Africa alone accounts for one in every seven new infections on the continent, and in 1998 was the source of over half of all 1.4 million infections in the southern African region (UNAIDS 1998a, d).

As in most sub-Saharan African countries, the HIV epidemic in South Africa is primarily heterosexual. Sixty per cent of HIV infections occur through heterosexual contact, and over half of those affected by the disease are women (UNAIDS 1998b). In keeping with this profile, vertical transmission is increasingly common in South Africa. Currently, it is the second most prevalent means of HIV infection in South Africa (Sidley 1998); an estimated 13 per cent of HIV infections can be attributed to it.

Mother-to-child transmission's increasing contribution to the epidemic only reinforces the need to consider the implications of sexual decision-making and negotiation among youth. Gage (1998) notes the importance of understanding such dynamics as a vital step in decreasing young people's vulnerability to HIV and other sexually transmitted diseases. Understanding youth's sexual decision-making and negotiation gives information on both the proximate and the background determinants of sexual and reproductive behaviour. This information is crucial to the creation of both policy and programs with the power to effect long-term improvement in young people's reproductive health.

### *Youth and HIV/AIDS*

In sub-Saharan Africa, the rate of newly acquired HIV infections is highest among 15 – 24 year-olds (UNAIDS 1996); South Africa seems typical in this respect.<sup>1</sup> The 1998 national sentinel survey found 21 per cent seroprevalence among 15-19-year-olds, a 65 per cent increase over the previous year's 12.7 per cent. This was the single largest recorded increase in any age group surveyed. For 20-24-year-olds the HIV rate was 26.1 per cent, a figure only slightly surpassed by those aged 25-29, 26.9 per cent.

### *HIV/AIDS: responses and awareness*

As illustrated by the quotations at the beginning of this chapter, the manner in which South African society approaches AIDS is complex and contradictory. Countless government and non-government programs have been launched to combat the spread of HIV (Flischer *et al.* 1999); matters related to HIV/AIDS and sex education are being incorporated into education curricula throughout the country (Shongwe and Varga 1997). Furthermore, both President Nelson Mandela and Deputy Vice-President Thabo Mbeki have repeatedly urged South Africans to speak out about HIV/AIDS, and increase efforts to prevent its spread. At the same time, Health Minister Nkosazana Zuma has assumed a seemingly contradictory stand on HIV-related therapies by endorsing clinical trials of the controversial new drug Virodene, but not AZT therapy for HIV-positive pregnant women, in spite of guarantees by major pharmaceutical companies of discounted supplies of the drug (Smith 1999).

Despite widespread education efforts, public sentiment toward HIV/AIDS and individuals affected by it remains extremely negative. Such an attitude is gruesomely demonstrated in the fate of Gugu Dlamini, a volunteer of the South African National Association of People Living with HIV/AIDS (NAPWA). After publicly disclosing her HIV-positive status, Dlamini was attacked by a mob and beaten, and died as a result of her injuries (McNeil 1998). That HIV is highly stigmatized in many Black South African communities

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<sup>1</sup> The epidemic is no doubt fuelled by the country's youthful age structure: 21 per cent of the population (8.8 million) is between the ages of 15 and 19 years, with a further 10 per cent (4 million) aged 20-24 (Central Statistical Services 1998).

has also been borne out in research among both youth and adults (Strebel 1992; Varga and Makubalo 1996; NPPHCN 1996; LeClerc-Madlala 1997; Swart-Kruger and Richter 1997). Moreover, these studies suggest that many South Africans view HIV infection with a mixture of fatalism, helplessness, fear, and even disbelief in its existence. Finally, there is growing evidence that many South Africans do not want to know their HIV status (Varga and Jones 1998; Varga 1998).

Amidst such paradoxical approaches to HIV/AIDS, there is nonetheless little doubt that a large proportion of South African youth are equipped with the facts to make safe choices in order to decrease the risk of HIV infection. Several studies have demonstrated adequate to high levels of HIV knowledge among South African youth.<sup>2</sup> In addition, self-perceived risk for HIV/AIDS also appears to be increasing among young South Africans (Naidoo *et al.* 1991; Richter 1996; NPPHCN 1996; Varga and Makubalo 1996; Varga 1997a; LeClerc-Madlala 1997; Varga and Jones 1998), though the potentially positive effect of increased self-perceived risk may be offset by feelings of fatalism and helplessness (Varga and Makubalo 1996; LeClerc-Madlala 1997; Swart-Kruger and Richter 1997). Research over the last decade has charted changes in the extent to which young people personalize the risk and seriousness of HIV infection. Such shifts in youth attitudes and perceptions concerning HIV may be in response to spiralling HIV infection rates in the mid-to late 1990s, and increased efforts at publicizing the phenomenon.

In Naidoo *et al.*'s (1991) study, 37 per cent of Durban university students saw reason to change their sexual practices (or had changed already) in order to avoid AIDS, and only 17 per cent considered themselves at risk for HIV infection. This combination of adequate knowledge and low self-perceived risk is confirmed in Richter's (1996) survey among Black youth in three large urban centres, and in a broad-based study conducted among young people throughout South Africa (NPPHCN 1996).

Other work among urban Black youth in KwaZulu/Natal Province suggests their realization of HIV's potential impact on their lives. Research has revealed a combination of high knowledge levels, high self-perceived risk of HIV infection, and feelings of helplessness to prevent it (Varga and Makubalo 1996; LeClerc-Madlala 1997; Varga 1997a).<sup>3</sup> Data from a recent community-based survey conducted in two former Black townships in Durban confirm such observations on HIV-related reactions among youth (Varga and Jones 1998).

Many 14-to-19-year-olds in the study were fatalistic about their relationship to HIV infection. A substantial proportion saw themselves as a corrupt generation being punished for their indiscretions through HIV infection (see also LeClerc-Madlala 1997); and nearly half of those surveyed were almost certain that they themselves would be infected before long. Nonetheless, nearly two-thirds of youth study participants stated they wanted to make some behavioural change, such as abstinence, monogamy or condom use, to decrease the risk of HIV infection.

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<sup>2</sup> Matthews *et al.* 1990; Friedland *et al.* 1991; Naidoo *et al.* 1991; Du Plessis, Meyer-Weitz and Stein 1993; Everatt and Orkin 1993; Van Aswegen 1995; Varga and Makubalo 1996; NPPHCN 1996; Richter 1996; Varga and Jones 1998. Some studies (e.g. NPPHCN 1996; Swart-Kruger and Richter 1997; Varga and Jones 1998) revealed that while most major messages concerning HIV were accepted, youth were confused about certain aspects of HIV transmission such as the role of shared utensils or mosquitoes in HIV infection. Thus, while general HIV-related knowledge was adequate, scope remained for dispelling inaccurate beliefs about the issue.

<sup>3</sup> KwaZulu/Natal Province has also long been the centre of HIV spread in South Africa. See Swart-Kruger and Richter (1997) for similar findings among urban street children.

Though evidence is mounting that young people have both the knowledge and the attitudes to effect behavioural change regarding HIV infection, it is uncertain whether these factors have led to significant shifts in their sexual practice. At present, there is little convincing evidence of real or large-scale sexual behavioural change in response to HIV education or other intervention efforts among South African youth (Matthews *et al.* 1990; Flischer *et al.* 1999).<sup>4</sup> In fact, most studies suggest a combination of adequate knowledge and continued high-risk behaviour. The challenge is to identify factors that block, or alternatively facilitate, behavioural change among South African young people. This study attempts to identify some of these barriers.

## Method

### *Subjects*

Study participants are male and female youth aged 11 to 24 years who are long-standing residents in the communities serving as study sites. There are no specific criteria for inclusion in the study other than age.

### *Study sites*

The research is based in one rural and one urban venue. The rural study site is a subdistrict of Umzinto-Vulamehlo District on the south coast of KwaZulu/Natal Province. Before 1994, it was part of the semi-autonomous homeland of KwaZulu and is typical of impoverished rural hinterlands throughout South Africa. Many parts of the subdistrict are not easily accessible by public transport. A large proportion of homes are not electrified, and many do not have piped water, relying on river water and rain barrels.

The urban site is a former Black township near Durban's city centre, but surrounded by several relatively wealthy suburban areas and shopping centres. It is a stable and long-established settlement, first founded in the 1940s. Compared to other similar areas in Durban, it has been relatively untouched by political and other violence.

### *Data collection*

Data were collected in three phases. The first was a series of focus-group discussions: 12 focus-group discussions, six per study site, were conducted with an average of eight participants in each. Focus groups were organized according to age: 11-14, 15-19, 20-24 years. Discussions were conducted in Zulu, taped, transcribed and translated by fieldworkers recruited from the community.

The second data collection phase was based on the Narrative Research Methodology described by the World Health Organization (1992, 1993a, b). The primary purpose of this method is to systematically identify the most common patterns of sexual behaviour and relationships among young people, as well as to explore the social consequences of their actions in this respect. It entails a series of youth-driven workshops from which a 'sexual life

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<sup>4</sup> With regard to the relationship between sexual behaviour change and education, a recent review by UNAIDS found that sexual health education does promote safer sex practices among young people if it is 'high-quality'. This entails focused curricula with clear statements about behaviour and the risks associated with it; learning activities that address social and media influences; strengthening communication and negotiation skills; encouraging open communication about sex; and use of grounded theories in stressing the social nature of learning (Grunseit 1997).

history' of a typical local adolescent is derived using narrative methods such as role play. Results of the workshop are then transformed into a questionnaire, based on vignettes or hypothetical situations derived from the life events identified by the youth, and other supplementary questions related to the situation being discussed. This phase is currently in progress. The sample size is 600 respondents, 300 for each site.

The third phase of the work is a series of in-depth interviews with selected youth who participated in earlier phases of the research. It is estimated that approximately 35 interviews will be conducted in each site.

### *Pilot research (1995-1996)*

Prior to this study, a small-scale pilot study was conducted in 1995-96. This consisted of a semi-structured interview format concerning matters related to sexual decision-making and negotiation. The interview was conducted among both female and male Zulu-speaking adolescents. Female respondents were 39 antenatal clinic attenders aged 15-19 years, recruited from a primary health clinic in a former township on the outskirts of Durban. Twenty-four males aged 18-26 years were recruited by snowballing through a local male university student contact.

## **Results**

### *Pilot study*

Selected results of the pilot study are included to provide a rough baseline for comparison to the current study (see Varga and Makubalo 1996; Varga 1997a). Data from the interviews suggested that HIV-related knowledge was adequate to high. Partner dynamics were characterized by avoidance of direct communication, unspoken assumptions about appropriate sexual conduct and male dominance in most aspects of sexual decision-making.

From comments by both male and female respondents, unprotected sex appeared to be an integral component of a serious love relationship. Moreover, men frequently noted the importance of achieving what in Zulu is known as *isoka* status. *Isoka* is a concept of male social success and popularity which entails among other things demonstration of multiple sexual conquests (Vilakazi 1962; Varga 1997a). In his study of life among the KwaNyuswa Zulu, Vilakazi describes the concept of *isoka*; 'To have a girl accept you as a lover is to get the assurance that you are a normal man. That is why [being known as an *isoka*] is such a value among the Zulu, for it gives social and psychological poise' (Vilakazi 1962:50).

There was considerable resistance to condom use on the part of both male and female respondents. Barriers against condom use included the negative moral implications of the practice (promiscuity, HIV infection), the fact that respondents felt it threatened trust within a relationship, and, for men, that it was physically uncomfortable.

Physical coercion was significant in shaping sexual practices. For women it appeared to be a major barrier to successful negotiation of the conditions, including timing and contraceptive use, under which sexual relations took place. Over half the female respondents reported refusing sexual advances from their most recent partner, who was nearly always the father of the child. Among these, 71 per cent stated the refusal was ultimately unsuccessful.

HIV was a negligible issue in sexual negotiation and decision-making. It was not discussed in the context of a relationship, and protection against infection was often seen as the other partner's responsibility. A considerable proportion of male respondents expressed disbelief in the existence of HIV/AIDS.

### ***Current study***

The first phase, focus-group discussions, has been completed and the second, the narrative component, is in progress. Results reported here are based primarily on focus-group data, with some reference to the narrative segment.

Four aspects of sexual decision-making and negotiation are investigated. First, young people's attitudes toward condom use are detailed. Second, two aspects of sexual negotiation are examined: decisions and dynamics surrounding initiation of sex and the role of coercion in a relationship. Also addressed are various forms of peer pressure in shaping young people's sexual behaviour. Finally, the role of HIV in young people's lives and their responses to discovery of HIV-positive status are explored.

### **Condoms<sup>5</sup>**

The opinions expressed here represent a range of young men's opinions in response to a general focus-group discussion question about condom use. The speaker quoted below openly admits that behaviour change is difficult but necessary in the face of HIV.

I do not like using condoms, because when I started having sex I did it without them. Now it is hard to get used to them. But because of AIDS I find I have little option but to start using them .... (urban male, aged 22).

The following words of a young male focus-group participant are significant in that even among very young teenagers in the study, messages seem to be penetrating with regard to the importance, not just the awareness, of measures to prevent HIV infection. This speaker was among the youngest participants in the study.

If all the people who say 'We are falling in love' would use condoms, [no one] would be affected with AIDS... (rural male, aged 13).

The third view quoted is typical of what is conventionally voiced concerning men's inability and unwillingness to use condoms (Worth 1989; Moore, Rosenthal and Mitchell 1996; NPPHCN 1996; Varga 1997a, 1998; Gage 1998). It was a popular viewpoint among male focus-group participants of all ages, and also figured prominently in narrative workshop role plays on the issue.

Using a condom ... breaks your dignity [male pride], because a girl feels that a condom during sex is nicer than your penis (rural male, aged 20).

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<sup>5</sup> Contraception for both males and females in general was an extremely weighty issue. There was considerable disagreement over the merits of females' contraceptive use, and the social connotations of such practices. Moreover, myths concerning the physical side-effects of contraception were very common. A comment by a 23-year-old rural male is typical in this respect: 'Contraception is not a good thing, especially if you have not had a child yet. We all want to have children, at least one'. It is beyond the scope of this study to address the relationship between females' contraceptive use and HIV; but, the high rate of adolescent childbearing combined with increasing rates of vertical transmission in South Africa makes this an issue necessitating immediate study and attention.

### *Personalizing condom use*

Part of the focus-group discussion schedule was designed to probe youth attitudes and responses when issues such as condom use were personalized. The way they generally discussed such matters made it clear that the majority of study participants were well aware of the benefits and the need to practise safer sex. However, questions remained as to the extent to which such opinions (and potential behaviour) would be upheld in the context of an individual's own sex life. Below is an excerpt from a discussion among urban girls in the 15-to-19-year-old focus group concerning how they would feel if a boyfriend requested the use of a condom.

L: I would have no problem with it.

Facilitator: Why do you feel that way?

L: Because then I will know I am having safe sex.

T: I would also know that I am safe from diseases.

Zm: I would be glad that he cares about my well-being.

P: I might be happy, but I might also think that he doesn't trust me if he is the one to initiate using condoms. I just don't know...

Si: I would ask him why he wants to use a condom.

Facilitator: And what do you think the reason would be?

Si: I would probably think that he has many girlfriends. And that would upset me a little.

Zi: Maybe it is because he knows bad things about you!

While at least two of the girls appeared to have embraced and personalized condom use as a means of ensuring safe and healthy sexual practices, the others expressed concern as to the negative connotations of introducing condom use into a relationship. From the conversation it appears that at least some of the girls felt that condoms might destabilize a relationship by introducing an element of distrust and suggesting inappropriate, promiscuous, sexual practices. Similar themes are apparent in a dialogue between 11-to-13 year-old girls on the same subject.

Facilitator: How do you feel about using condoms in a relationship?

The: I think it is wise to use a condom because you can sleep with somebody who is HIV-positive and the condom can protect you from getting infected.

Phi: I was also going to say that a condom is a good thing because it protects you from AIDS infection...

Facilitator: Okay. How would you feel if your boyfriend wanted to use a condom with you?

Pik: I would be very disappointed.

Aya: I would be heartbroken. It means he does not trust me.

The: I agree with her. It would mean he does not love me.

Nhl: I would refuse to use a condom. It might burst inside my womb.

Phi: I also agree with what is being said...I would refuse the condom. It means my boyfriend does not trust me.

Initially it seems that even these very young girls advocated protected sex. However, their responses shifted radically when they were faced with the prospect of personally using condoms. Both the girls who were at first supportive quickly changed their minds. Like the older age group, they relied on many of the traditional stigmas surrounding condom use as a reason to refuse protected sex.

***Introducing condoms into a relationship: who refuses to use condoms?***

The following dialogue is drawn from a scene devised and acted by youth in the rural narrative workshop. As noted above, workshop participants construct a story made from discrete events that typify local adolescents' experiences regarding sexuality and reproductive health issues. They then create characters and act selected events in the life story. In the case of the rural workshop, participants created two characters: Zodwa, a 16-year-old girl and Themba, her 19-year-old boyfriend. At this point in the story, Zodwa and Themba have fallen in love but have not had sex yet. The following dialogue is taken from a scene workshop participants entitled *Who Refuses to Use Condoms?* Zodwa and Themba are negotiating the terms under which their first sexual encounter will take place.

Z: Themba, will you wear a condom?

T: A condom! What's the problem, Zodwa? You know I can't use this thing.

Z: You know I can't have sex with you if you don't wear a condom.

T: Let's just do it a little bit....

Z: No, we can't do anything [without a condom]. Please, let's just use a condom. If you don't have one, I will give you one (pulls a condom from her purse).

T: It's hard for me. Why do you want to use a condom? Don't you love me?

Z: If you don't want to use a condom, let's just stop the relationship.

T: Just like that? For the sake of a condom?

Z: I want a condom.

T: You have it! You usually carry condoms with you? Everywhere you go?

Z: Yes, I normally have one with me.

T: [But] I won't be able to feel ... anything if I use it. I cannot have sex with you if we have to use a condom...

Z: I want a condom... But I really want to do it [have sex]. Next time we will use a condom...

T: Okay....

At first, Zodwa was determined to use condoms the first time they had intercourse. She even came prepared with her own, which she gave to Themba. However, as he made excuses and eventually refused to have sex unless they dispensed with condoms, her resolution weakened. Finally, she capitulated, and the couple left the issue of condom use unresolved. Several themes are noteworthy in this interaction. First, although Zodwa was the one to take the initiative in suggesting protected sex, eventually Themba's wishes prevailed. Her proposition was met with considerable resistance from Themba, who saw no need for protected sex and relied on conventional stigmas such as physical discomfort or endangering trust as reasons to avoid condoms (see also Worth 1989; Sibthorpe 1992; Sobo 1993; Pivnick 1993; NPPHCN 1996; Richter 1996; Varga 1997a, b). This highlights the unequal power dynamics young people experience concerning sexual issues, and the manipulation of the situation by the male partner to enforce his wishes (see Gage 1998). This interaction was echoed in the urban narrative workshop. There, the male character refused condoms because, in his words, 'You don't love me then [if you want to use a condom].' Later, he stated: 'I [won't] eat a lollipop in its wrapper'.

The fact that Zodwa was the first to suggest condom use and that she actually carried them with her was extremely significant in the development of her interaction with Themba. While this is detailed below, suffice it to say that in this case, the negative connotations of condom use also extended to the user. That is, because Zodwa was the one to introduce the issue of condom use into the relationship, she fell under immediate suspicion concerning her sexual proclivities. Ironically, Zodwa's attempt to enforce safe sex practices branded her as promiscuous and a carrier of HIV.

### **Sexual dynamics: initiating sex and coercion**

The issue of initiating sex in a relationship was one which arose repeatedly in both focus-group discussions and the narrative component. Perhaps unsurprisingly, it was generally the male partner who initiated sexual advances, and there was very little direct communication or negotiation on the issue before its occurrence. This is illustrated by the manner in which young men in both the rural and urban focus groups viewed the matter. In this first extract, rural men in the 20-to-24-year age group discuss the matter of introducing sex into a relationship.

B: In most cases it is the boy who takes the decision as to when to have sex because a girl is too shy to do that. The girl usually starts refusing (and playing hard to get), but in the end she must agree.

St: That's true. In fact, most of the time you don't discuss when to have sex or who is going to decide about that. It just happens, and the girl must know what to expect if I propose to her. What normally happens is that you propose to a girl and on the same day it happens. No discussion.

B: That, or ... you have sex and then and there when you discuss the issue. To those who really love each other, they don't have to discuss it because they know the consequences of having sex.

The conversation was similar among 14-to-19-year-old boys discussing the same issue.

Ni: ...It is always the boy who tells the girl to visit him at home. Although he may not tell her exactly what she is visiting him for ... it will become obvious when they are at the boy's house.

Facilitator: What if the girl refuses?

Si: Then we would fight. If she does not agree...

Facilitator: Does that mean that you have to force the girl to have sex even if she does not want or like to do it?

Si: There are no negotiations in that issue. If my penis wants it, it must get sex. No other way about it.

Sa: It also depends on whether you love the person...

Ni: That's right. Sometimes girls say that you do not love your boyfriend very much if you do not have sex with him. ... You have to prove your love by having sex...

At least three significant themes are illustrated in these two male dialogues. First is the lack of direct communication on the issue of initiating sex. Rather, youth seem to rely primarily on implicit cues in alerting each other to expectations of appropriate sexual conduct. Another issue is the acceptance of male dominance and use of force in initiating sex. As the fourteen-year-old ('Si') in the discussion above stated, in sex 'there are no negotiations on that issue'. Both these themes also arose repeatedly among urban men. In response to a comment on the acceptability of coercion in initiating a sexual relationship, one 23-year-old urbanite stated: 'Once you have kissed each other that means you are preparing for sex. If she refuses at that point you must just force her'. Finally, very apparent is the pressure young people feel to have sex in order to prove love, as described by the final speaker.

Pressure to have sex in order to prove love was also a theme demonstrated in the narrative workshops. In one role-play in the urban group, the male character stated: 'Our love is not solid enough. We have to have sex to make it solid and stable'. When his girlfriend said they should wait until marriage, his response was: 'Marriage? How can I marry you not knowing whether you care for me? Let me have a small taste [of sex to show that you love me]'.

The prevalence of such dynamics is also reinforced by comments by female focus-group participants. Below is an excerpt from a focus-group discussion on the same issue between 14-to-19-year-old girls in the urban venue. Note the agreement among the girls concerning lack of communication, male dominance in sexual decision-making and the role of coercion in sexual dynamics.

Zm: It is the boy who decides.

Facilitator: Lisa seems to disagree....

L: It should be a mutual decision, made by both of them. If a woman doesn't want to do it, she should be respected.

Facilitator: Do couples usually discuss these issues?

ZZ: Some do discuss, but more often these things are not discussed. They just happen.

Facilitator: Let us suppose they do discuss it. But what happens if one partner doesn't want to do it?

Zm: If it is the woman who doesn't want it, the boy will beat her up [until she is willing].

Zi: Other guys just dump you and find someone who is willing....

The matter of coercion in sexual negotiation was also addressed directly in the focus-group discussions. The following commentaries were offered by female focus group participants in response to a question concerning the acceptability of coerced sexual relations. The first extract is from a conversation between urban women in the 20-to-24 year age group.

G: It [forced sex] does happen, usually because of the situation the man finds himself in. He can't control himself if he sees a woman he likes. Maybe by looking at you he is turned on and cannot wait.

No: But really, I don't think a woman should be forced. If you do not want to, a man should understand that. And he must listen to you and not force you.

D: I think a situation where he could force is when you attract him, as Guzze says. And when you respond positively when he touches you, you show that you like it. That is why he forces you. You give the signals he is looking for, that say you want it too.

Many of the themes apparent in men's commentaries are reiterated here. Two of the three women in this dialogue seem to implicitly sanction, or at least excuse, male dominance and coercion in sexual relations. Men are described as naturally unable to control themselves when faced with a potentially attractive sexual situation. Further, there is a strong suggestion that in responding positively to male sexual advances, women invite sexual coercion.<sup>6</sup> Finally, as among men, sexual communication is described as indirect and non-verbal. The words of the final speaker vividly illustrate the purely physical nature of sexual dynamics between partners. In contrast to their older counterparts, most 14-to-19-year-old urban girls seemed to question the acceptability of coerced sex in the context of a relationship.

L: It is never acceptable for a guy to force a woman to have sex.

T: But they do it, just to destroy the woman and get what they want.

Pr: I do understand why a woman should be forced. Because after all, these people are in love with each other. If you love someone you show it by having sex.

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<sup>6</sup> These findings are consistent with work by Wood, Maforah and Jewkes (1998) among Xhosa youth. In that study, young women described physical coercion in a sexual relationship as normal and a sign of love from their partners. Gage (1998) also discusses these factors among youth in the developing world. See also essays on masculinity by Cornwall and Lindisfarne (1994).

Facilitator: How common is sexual violence in this community?

Zi: It is very common.

L: I actually think it is the norm. It is the way people interact sexually.

T: It really is common. I think guys enjoy forcing sex.

ZZ: I think guys just do it so they can feel proud of themselves for getting sex.

Clearly, the majority of girls in this focus group discussion felt victimized by forced sexual relations. They were resentful of the control men had over them through the use of coercion in sexual relations. Nonetheless, while these young women were uncomfortable with the concept of forced sex, they confirmed the older group's opinion that coercion is a common occurrence in young people's sexual dynamics. Quite unnerving is the depiction of forced intercourse as the 'norm', an image also described by other female focus groups. Moreover, consistent with older women, there was at least one suggestion (by the third speaker) that coercion is acceptable in the name of love (see also Wood *et al.* 1998).

### Gender and peer pressure

[In] a group of friends ... one of the girls might be in love with one of the boys. The other girls are then influenced by [her] to start getting involved with boys in [the] group. If the boys do not propose, the girls will go after the boys and make themselves available. They will advertise themselves to the boys. Then some times when a boy wants to have sex with a particular girl, he will tell another girl to go and influence that one to agree to have sex with him (urban girl, 13 years old).

The role of peer pressure in shaping sexual practice arose repeatedly in youth discussions. It was a prevalent theme in all age groups, and was frequently mentioned by both males and females. Moreover, youth seem to be subject to pressure by peers of the same sex as well as potential partners; peer pressure has multiple dimensions. It is clear that young people felt pressure to incorporate sex into their social lives from an early age. The speaker above is only thirteen years old, and already speaks of sexual activity as a normal part of her social group's activities. Her comments were reinforced by the following short exchange between 14-to-19-year-old urban girls. Note the role of peers of the same sex in creating pressure to initiate sex early but also to engage in multiple partnerships.

Si: Often you will feel pressure to sleep with a boy because your friends are doing it.

S: They can even make you agree to love someone and have sex with him.

Zm: Your friends can even accompany you to see the boy, and push you to get involved with him.

ZZ: They will say you need two legs to stand. So you can't have just one boyfriend. You need more than one in case you are disappointed....

Another significant issue concerning peer pressure was the social burden that young men felt in expectations concerning their sexual conduct. Such pressure was discussed

repeatedly among young men of all ages, and extended not only to sexual involvement but also to parenthood. Such matters are illustrated in the following comment:

I think we get pressure from our peer group to be in love (become involved, date). If you don't have a girlfriend others call you bad names and make fun of you.... The other thing is that when a man our age has a child, you also wish to have one. Everyone waits for you to have a child, and looks. This also happens with numbers of girlfriends. We all want to have at least the same number or more than the others. It's like a competition for all these issues (rural male, aged 22).

The experience of multiple kinds of peer pressures on male sexual behaviour is also apparent in the following dialogue among urban boys in the 14-to-19-year age group.

Ni: I think sex is not important, but if I don't have sex with my girlfriend, my friends will call me a fool. Also, if you do not have sex with your girlfriend, she will leave you. So you have to do it even if you don't want to get involved in sex.

Facilitator: So for you, you have sex because there is a lot of pressure to do it, and you are being forced to do it?

Ni: I am doing it because there is pressure from my friends and because of the fear that my girlfriend will leave me if I don't do it.

Mf: I agree with Nicky, that sometimes our friends force us and laugh at us, and they tell you that your girl will leave you if you do not have sex with her.

Si: But I think it depends on the person. If you are able to resist pressure from your friends you won't feel you have to do it.

Mz: I have been a victim in this because my girlfriend dumped me because I didn't want to have sex. So it happens a lot.

### **Dynamics of confronting HIV status: *The HIV-Positive Baby***

The last part of this chapter is drawn exclusively from the narrative segment. This dialogue was devised and acted in the rural narrative workshop. It involves the same two characters, Zodwa and Themba, who have by now been through a series of situations together, including pregnancy and arguments over paternity (a matter which remains unresolved). Zodwa recently discovered that both she and the baby are HIV-positive. In this scene she confronts Themba with the situation. Workshop participants entitled it *The HIV-Positive Baby*.

Z: Hi, Themba. I've come to talk to you about the child. The baby is sick, Themba.

T: What's wrong with him?

Z: The child is HIV-positive.

T: What?

Z: AIDS.

T: Well, you are the one who came with that disease!

Z: It's you, Themba...

T: There is no way I have AIDS!

Z: How do you know?

T: I have never had any symptoms. Look at me!

Z: You cannot see AIDS or touch it with your hands. This disease is between you and me, and we must have a test...

T: I will see about having a test, but it is you who really must go, because you are infected, not me. It is your responsibility to take care of this...

This exchange illustrates the fact that acknowledgement of HIV infection and partner communication on the issue (to say nothing of caring for the child) is extremely stressful for these two partners. The issue is further complicated by Zodwa's behaviour when she and Themba first began seeing each other (see *Introducing Condoms into a Relationship* above). The members of the workshop observing this interaction pointed to the fact that Zodwa's previous behaviour, carrying condoms and insisting upon their use, made it likely that she was the one to have brought HIV into the relationship. Thus, Zodwa was blamed by the workshop participants for spreading HIV, even though it was well known that Themba was a womanizer and had other sex partners during his relationship with Zodwa.

## Discussion

### *Barriers to HIV-related behaviour change*

What do these results suggest about barriers to positive behavioural responses amidst the threat of HIV infection? First, it is clear that youth in this study are part of a socio-sexual culture not conducive to equality in sexual decision-making and dyadic negotiation. It appears that different sexual standards operate for men and women regarding appropriate sexual comportment, and these differences encourage high-risk sexual behaviour.

It was obvious across all age groups of the young people in this study that men were the primary decision-makers concerning sexual matters. This was a fact acknowledged, and seemingly accepted, by the majority of both male and female study participants. Only a small minority of young women in the study questioned this dynamic. For the most part, female study participants appeared to remove themselves from the decision-making process altogether, a reflection of women's passive role in sexual relations. This phenomenon has been observed among both adults (Worth 1989; Fullilove *et al.* 1990; McGrath, Rwabwukali and Schumann 1993; Pivnick 1993; Romero-Daza 1994) and youth (Fullilove *et al.* 1990; Tolman 1994; Grunseit 1997; Lear 1997; Gage 1998); and among partners in both Africa (McGrath *et al.* 1993; Romero-Daza 1994) and the West (Worth 1989; Pivnick 1993; Lear 1997).

Several studies cited here (McGrath *et al.* 1993; Romero-Daza 1994; Gage 1998) describe cultural constraints experienced by women in negotiating safer sex, because of the general acceptability of men's high-risk sexual practices. For example, McGrath *et al.* (1993)

demonstrated that in Baganda culture men were permitted and even encouraged to have multiple sex partners; women were powerless to change this situation despite concern over HIV infection. This also appears to be the case for Zulu youth in this study. While the concept of *isoka* appears to be waning it is still relied upon to justify men's sexual behaviour. Moreover, in the questionnaire pilot, young men frequently characterized a man with many sexual partners as 'successful' or *isoka*, while a woman in such a situation was described as a 'bad girl' or a 'whore' (Zulu, *isifebe*).

Similar attitudes have been recorded in other studies of young people's sexual activity. Xhosa youth appear to hold many of the same beliefs about gender-specific sexual behaviour as those revealed here (Wood and Jewkes 1998). Moreover, Lear (1997) describes such gender-specific double standards among American college students. While male college students are praised for multiple sex partners, 'being seen as sexually experienced for a woman [including carrying and using condoms is] still more stigmatized than being seen as sexually inexperienced' (Lear 1997:108-109). In contrast, a few studies have demonstrated considerable female decision-making power in environments characterized by women's economic empowerment (Kline *et al.* 1992; Orubuloye, Caldwell and Caldwell 1993) and non-traditional gender roles (Kline, Kline and Oken 1992). Neither of these elements is part of most young Zulu women's lifestyle: in the narrative component of the study, a frequently mentioned issue is that of young women prostituting themselves or taking 'sugar daddies' out of economic need. Comments of several young women reported here reinforce the traditional gender stereotype of Zulu women as submissive.

For youth in this study, the seemingly commonplace nature of gender-based violence in the context of sexual relations no doubt reinforced male sexual decision-making dominance. It appears that gender-based violence and coercion continue to be an integral component of youth sexual culture. In this study coercive sex (and related to this men's inability to control themselves in sexual situations) was viewed as acceptable by both young men and women, and generally seen as a male mandate. Such an interpretation of coercion, that it was a natural male reaction, provided forced sex with considerable social legitimacy.

The significance of physical coercion as a cultural phenomenon as well as an obstacle in sexual negotiation is consistent with the pilot study (Varga and Makubalo 1996; Varga 1997a), and has been described in other recent South African research on sexual issues among youth (see NPPHCN 1996; Wood *et al.* 1998). Wood and Jewkes found that among Xhosa youth, masculinity was defined largely 'in terms of control over women' (Wood and Jewkes 1998: 22), with young Xhosa women accepting this concept. In this respect they noted that 'The legitimacy of ... coercive sexual experiences was reinforced by female peers who indicated that ... submission was the appropriate response' (Wood and Jewkes 1998:23).

The role of gender-based sexual violence in society has also been highlighted elsewhere. Both Sanday (1981) and Heise *et al.* (1994) explore the cultural, economic, political and legal factors which sustain gender-based violence. A series of essays compiled by Harvey and Gow (1994) explores 'culturally embedded' sexuality and violence (Harvey and Gow 1994:12); with the conclusion that in many societies the two are tightly linked means of expression. In the same volume, Moore suggests that gender-based violence can best be understood 'as a sign of a struggle for the maintenance of certain fantasies of [male] identity and power' (Moore 1994:154).

Nonetheless, while it may be a significant component in the socio-cultural definition of gender and gender relations for Zulu youth, in its current form coercive sex has rather obvious negative connotations for HIV prevention. Combined with the stigma associated with practices such as condom use or abstinence, forced sexual relations severely hinder the possibility of either partner successfully enforcing, or reinforcing, sexual behaviour which might prevent the spread of HIV among youth. Gender-based violence is increasingly

recognized as a significant barrier to safe sex practices in general (Sanday 1981; Heise *et al.* 1994; Heise, Moore and Toubia 1995; Grunseit 1997), as well as specifically in an intimate or steady sexual relationship where coercive sex is often more difficult to identify (Day 1994; Heise *et al.* 1994; Warshaw 1994; Lear 1997). This is particularly the case in societies where forced sexual relationships are tolerated as acceptable means of sexual communication.

Young people's sexual dynamics were characterized by poor communication over the circumstances of intercourse. Most youth simply did not discuss how and when sex would take place, and thus were probably unprepared for it when it happened. This is consistent with other work among young people in the US (Lear 1995, 1996, 1997), Australia (Moore *et al.* 1996; Grunseit 1997), and elsewhere in sub-Saharan Africa (Gage 1998).<sup>7</sup> Couples who did talk about such matters usually communicated through oblique references to sexual issues, rarely confronting specifics such as timing or contraceptive use by either partner. Lear (1997) notes that among American college students such communication patterns led to lack of preparation for sex and thus frequently to unprotected intercourse.

In this context, gender-based violence may have served as a way of communication between partners. Wood and Jewkes's descriptions of young Xhosa males' motivations for sexual violence make it obvious that men's violent reactions were means of showing various emotions; with female partners at times interpreting such behaviour as demonstrative of affection or commitment. It is likely that gender-based violence served a similar function among the young people in this study.

Related to poor dyadic communication was an apparent lack of clarity concerning partners' expectations of each other. Both young men and women in this study were often caught up in what they 'should' be doing sexually rather than what they themselves, or their partners, wanted; leading to misunderstandings between partners over sexual matters. Such dynamics are consistent with research conducted among youth in other countries. Lear (1996) found that American college students possessed misconceptions about the motivations of their partners, which led to confusion and lack of preparation for sexual situations. If young people cannot communicate openly and effectively with each other on this level, they are unlikely to be able to discuss, much less agree upon, matters related to HIV in the context of sexual behaviour. Factors such as partner communication and negotiation skills have been recognized as crucial in the success of programs focused on sex education and behavioural risk reduction among youth (Grunseit 1997).

Another factor significantly diminishing Zulu youth's ability to negotiate safer sex was peer pressure. Both focus-group discussions and the narrative component demonstrated this as a prevalent part of young people's social and sexual milieu. Moreover, peer pressure came from peers of the same sex as well as potential partners. This is generally consistent with other research concerning the effect of social and peer pressure on sexual behaviour among youth in both developed countries (Moore *et al.* 1996; Lear 1997; Alexander and Hickner 1997; Burack<sup>8</sup> 1999), and developing countries (NPPHCN 1996; Wood and Jewkes 1998). Furthermore, it seems that peer pressure is a common factor in most young people's decisions not only to become sexually active but to engage in unsafe sex practices (Grunseit 1997). Similarly, research suggests that those young people who are less susceptible to peer pressure or more successfully resist it, are more likely to practise safe sex (Gage 1998).

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<sup>7</sup> Such sexual communication dynamics have also been observed among adult partners in Kenya (Balmer *et al.* 1995) and Uganda (Blanc *et al.* 1996).

<sup>8</sup> Working among British youth, Burack (1999) found that peer pressure to engage in risky sex was a factor particularly among very young boys (aged 13 years), and less so among older boys.

It was apparent that both male and female study participants felt pressed to fulfil certain social expectations in sexual matters. Wood *et al.* (1998:236) also found such dynamics at work among Xhosa youth's 'peer context'; though their study was confined to females' perspectives on coercive sex. Here, comments of men across all age groups reflect the fact that they too felt compelled by peers of both sexes to live up to such expectations (see De Gaston, Weed and Jensen 1996; Lear 1997; Wood and Jewkes 1998; Burack 1999). Thus, in order to effect long-term behavioural change both sexes must be empowered to feel free to make safe-sex choices.

Several points are significant concerning the relationship between peer pressure and sexual behaviour. First, peer pressure may be important in pushing youth not only to initiate sex early, but also to engage in multiple sexual partnerships. This was quite evident in the description provided by the thirteen-year-old urban girl quoted above who stated that 'a boy will tell another girl to go and influence that one to agree to have sex with him'. Moreover, having multiple sex partners also appears to be part of the requirement for peer acceptance.

The social stigmas that interfere with the personalization of safe-sex practices among Zulu youth also present a significant obstacle to behaviour modification. First, the stigma attached to HIV certainly limits young people's ability to discuss it, make changes in personal sexual habits, and confront the possibility of HIV infection. Themba's reaction to Zodwa's news concerning their child reflects this. Moreover, in Zulu youth culture there is continued emphasis on the importance of not only sexual involvement but unprotected sex as proof of love and commitment, since condom use suggests promiscuity and lack of trust. This is an apparently common phenomenon, as several studies have revealed such condom stigmas among youth (see Moore *et al.* 1996; Varga and Makubalo 1996; Varga 1997a, b; Lear 1997; Wood, Maepa and Jewkes 1997; Flischer *et al.* 1999). Further, in such an environment, for many Zulu youth safe sex practices such as abstinence are not a realistic option. As one sixteen-year-old urban male put it, '... You have to prove your love by having sex'. Such anti-abstinence sentiment has also been observed among other South African youth (Flischer *et al.* 1999).

Finally, at least some youth may be tired of hearing about HIV and AIDS; this observation comes from events taking place in the urban field site. When recruiting for the urban focus-group discussion segment, we found many urban young people reluctant to participate until they were reassured that it was not an exercise focused on HIV *per se*. Many said they were tired of hearing about AIDS. Further, preliminary data analysis suggests that HIV/AIDS seems to be less of an issue in urban than rural youth's social and sexual environment. One explanation offered by the urban research team is that urban youth take HIV for granted and are no longer interested in talking about it.

Most of the factors hindering safe-sex practices among these Zulu youth also appear to characterize sexual decision-making and negotiation among youth in much of sub-Saharan Africa. A recent review by Gage (1998) describes youth sexual culture distinguished by varying degrees of self-perceived risk, unequal gender power relations, gender-based sexual coercion, lack of dyadic communication, and significant influence of peer pressure and group norms in determining sexual practices. Thus, it seems young people throughout sub-Saharan Africa face similar barriers to safe sex practices in the context of HIV/AIDS.

### *Groundwork for positive behaviour change*

While obstacles to behaviour modification are considerable, there is still reason for optimism concerning the potential for positive HIV-related behaviour change among Zulu youth. In many respects, it appears there has been change in attitudes and approaches toward HIV; this provides the groundwork for behaviour modification.

First, HIV is increasingly part of the sexual discourse of youth. The fact that young people are talking openly about HIV can be construed as positive. This appears to be a shift from even a few years ago. One fieldworker recently remarked: 'Three years ago they never would have been talking about AIDS like this'. At the very least, it suggests that perhaps the stigmas against HIV are starting to disappear.

Moreover, youth are internalizing HIV infection as significant and life-threatening. Even the youngest age group in this study recognized the need for HIV prevention and safe sex. HIV is seen as a basic part of youth's sexual experience, and it seems that perception of the risk of infection may be increasing. This is much more than just knowledge. It is also the realization of the impact AIDS has on all young people's lives. Flischer *et al.* (1999) note that those with high self-perceived risk of HIV are more likely to actively modify their behaviour (see also Moore *et al.* 1996). In this respect, some youth welcome safe sex practices. There are indicators of willingness to use condoms and embrace the positive value of practising safe sex.

Finally, at least some young people seem to be recognizing the need to modify gender-specific behaviour patterns. In this respect, the apparently shifting value of *isoka* status is one example. In the pilot study a few years ago, men were unanimous on the importance of achieving *isoka* as a means of social recognition and manhood. In contrast, a 24-year-old urban male focus group participant remarked: '*Ubusoka* is still in existence, but it is no longer as important because people are now afraid to be *amasoka* due to AIDS'.

## Conclusion

While there are obvious and significant barriers to positive behavioural changes among Zulu youth in KwaZulu/Natal, this study suggests a change has begun in youth's world view of HIV; this is a significant component of starting to change behaviour. The questions, however, remain as to what else needs to be done to enable long-term behaviour modification, how soon the shifts observed here will translate into large-scale change, and if such change will take place soon enough to affect the HIV epidemic in South Africa.

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